STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155328	A. BUILDING 00 B. WING	08/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPARK REHABILITATION CENTER	25 S BOEHNE CAMP ROAD EVANSVILLE, IN47712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Investigation of Complaint IN00094580. Complaint IN00094580 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F282, F309, F328, and F329. Survey dates: 8/13 and 8/15/11 Facility number: 000221 Provider number: 155328 AIM number: 100267620 Survey team: Jennie Bartelt, RN Census bed type: SNF: 13 SNF/NF: 79 Total: 92 Census payor type: Medicare: 12 Medicaid: 66 Other: 14 Total: 92 Sample: 5 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	The Preparation or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law. We respectfully request this Plan of Correction serve as our allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 8/17/11 Cathy Emswiller RN			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the	F0157	F 157	09/12/2011

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	facility failed to ensure the physician was notified with results of a chest x-ray and abnormal breath sounds for 1 of 5 residents reviewed related to physician notification in a sample of 5. (Resident C) Findings include: The clinical record for Resident C was reviewed on 8/13/11 at 12:25 p.m. Nursing Progress Notes for 7/8/11 at 2:30 p.m. indicated, "Chest X-ray today d/t [due to] congestion. Family request tx to be routine. Triage will return call [symbol for with] orders regarding breathing tx [treatment]." Nursing Progress Notes for 7/8/11 at 2:40 p.m., indicated, "X-ray notified of order." Nursing Progress Notes for 7/8/11 at 6:00 p.m., indicated, "N/O [new order] per triage. Albuterol Neb [nebulizer] tx BID [twice a day] et [and] q [every] 4 [symbol for hours] prn [as needed]. Pharmacy notified. Left message for family." Report of a chest x-ray, dated 7/8/11, indicated the document was faxed from radiology on 7/8/11 at 8:56 p.m. The report indicated, "Impression: Chest: Mild pulmonary vascular congestion in		Resident C no longer resides at the facility. An audit was conducted to identify residents that have physician orders for x-rays and or nebulizer treatment over the last 30 days to ensure the physician was notified of the x-ray results and notification of residents breath sounds according to the physician order. Licensed staff have been re-educated on policy and procedure for " Physician Notification" and respiratory flow sheets. Physician orders for x-rays and respiratory treatments will be reviewed by the Interdisciplinary Team to ensure physician notification was completed. DON/Designee will audit the Interdisciplinary Teams clinical review sheets 5 X weekly for 6 months to ensure follow through on physician notification. Identified non compliance of physician notification will result in 1:1 re-education with progressive discipline up to and including termination. Results of the audits are reviewed by the QA committee for recommendations. Systemic changes will be completed by 9-12-11	

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	both lower lung fields. Comment: ...Clinical correlation is requested...." A stamped "Faxed" on the report indicated, "7/9/11." During interview on 8/15/11 at 11:30 a.m., in regard to when the physician was notified of the results of the chest x-ray for 7/8/11, the DON indicated the physician would have received the report before the facility so would have been aware of the report when orders were received for nebulizer treatments twice daily on 7/8/11 at 6:00 p.m. Documentation failed to indicate the physician was made aware of the results of the chest x-ray and need for clinical correlation. The Respiratory Treatment Record for July 2011 for "Albuterol U/D [unit dose] q 4 [symbol for hours] prn cough" indicated the nebulizer treatment was administered 7/9/11 at 8:00 a.m. and included pulse and respiratory rates and breath sounds of wheezes and diminished, before and after the treatment. Documentation failed to indicate the physician was notified of the wheezes and diminished breath sounds. Other doses were administered one to two times daily through 7/16/11, with indication of pulse and respiratory rates and breath sounds of clear/diminished or diminished before			

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	treatments and clear/diminished or clear after treatments. Documentation failed to indicate the physician was notified of the diminished breath sounds. Nursing Progress Notes for 7/13/11 at 8:30 a.m., indicated, "Returning from rehab dining. Color pale. Unable to walk. Placed in W/C [wheel chair] returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D5 1/2 NS @ [at] 60 [dextrose 5%, one-half normal saline] at 60 cc [cubic centimeters] per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective: ...Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distress...pale, warm, ashy around lips, does have occasional cough, Lungs: within normal			

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	limits/clear; rales [sic]...lack of muscular coordination. When re [checkmark] [recheck] about an hour later, pt alert, color good, talking & visiting [symbol for with] family. O2 still variable, but breathing reg [regular] & even, non-labored....Plan: Recheck as necessary...." Physician's orders, dated 7/13/11, indicated, "O2 [oxygen] at 2-4 L/PNC. Keep sats greater than 90%, IV D5NS @ 60/hr [sic]. Stat [immediate] chest x-ray, CBC [complete blood count], BMP [basic metabolic profile], UA & C&S [urinalysis with culture and sensitivity." A report of the chest x-ray, dated 7/13/11, indicated, "Impression: Chest: ...infiltrate in the right lower lung field....Comment: ...infiltrate in the right lower lung field. The lung fields are otherwise essentially clear." Physician's orders, dated 7/13/11 at 1:00 p.m., indicated, "Levaquin 500 mg po [by mouth] dly [daily] X [for] 10 d [days] pneumonia...." This federal tag is related to Complaint IN00094580. 3.1-5(a)(2) 3.1-5(a)(3)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure physicians' orders were followed for treatments and snacks for 3 of 5 residents reviewed related to following physician's orders in a sample of 5. (Residents B, C, and F) Findings include: 1. The clinical record for Resident C was reviewed on 8/13/11 at 12:25 p.m. A physician's order, dated 7/26/11, indicated, "Annusol cream to rectum qd [every day] & prn hemorrhoid or rectal pain." The Medication Administration Record (MAR) for the entry for Annusol indicated a nurse's initials with a circle around on	F0282	F 282 Resident C no longer resides at the facility. Residents that had physician treatment orders dated 8-11-11 are currently being provided treatment per physician order. Residents that have physician orders dated 8-9-11 for mid morning and evening snacks are being given snacks per physician orders. Physician orders from the last 30 days were reviewed to ensure proper documentation and follow through were completed. Current residents are receiving treatments and snacks per physician orders. Facility staff were re-educated regarding following physician treatment orders and documentation. Physician orders will be reviewed by the Interdisciplinary Team to identify	09/12/2011

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	7/27 and 7/28/11. Documentation failed to indicate the meaning of the circles. The MAR indicated no nurse's initials to indicate the medication was administered on 7/30/11. The medication was administered on 7/31 and 8/1 through 8/5/11, when the resident was discharged to another facility. 2. The clinical record for Resident B was reviewed on 8/13/11 at 11:30 a.m. An Optometric Exam Form, dated 8/11/11, indicated, "Reason for Visit (Vision Quality): Crusty lids." A physician's order, dated 8/11/11, indicated, "Baby shampoo lid scrubs ou [both eyes] q [every] a.m. - blepharitis o.u." A copy of the Treatment Administration Record received on 8/13/11 indicated no nurse's initials to indicate the treatment had been provided. A copy of the Treatment Administration Record received on 8/15/11 indicated a nurse's initials with a circle around on 8/12/11, and a nurse's initials indicating the treatment had been provided on 8/13/11. No nurse's initials indicated the treatment was provided on 8/14/11. Documentation failed to indicate an		residents with orders with snacks. Dietary will audit the delivery and consumption of resident snacks daily. Administrator/Designee will review audits 5 x weekly for 6 months. Identified non compliance of POC will result in 1:1 re-education with progressive discipline up to and including termination. Results of the audits are reviewed by the QA committee for recommendations Systemic changes will be completed by 9-12-11	

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	explanation of the circled initials. During interview on 8/15/11 at 11:40 a.m., the DON indicated the circled initials on the MAR meant the medication was not administered and the MAR should include an indication of why the medication was not administered. 3. Resident F's name was included in a list of interviewable residents provided as requested at the Entrance Conference with Assistant Director of Nursing [ADON] #2 on 8/13/11 at 9:30 a.m. During interview on 8/13/11 at 10:45 a.m., Resident F was observed seated in bed. She indicated she was waiting for her morning snack as ordered by the physician. She indicated she had just had a shower, was diabetic, and was getting hungry. She indicated she gets a headache when she gets hungry. She indicated she would prefer a lunch meat sandwich for her snack. The clinical record for Resident F was reviewed on 8/13/11 immediately after the interview. The record indicated a physician's order, dated 8/9/11, for "Please make sure pt. [patient] is getting mid morning and evening snacks. Please have dietary monitor whether pt. is eating her snacks."			

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	On 8/13/11 at 11:00 a.m. ADON #1 was requested to assist in obtaining Resident F's morning snack. ADON #1 went to the kitchen door and could be heard asking staff inside if Resident F's mid-morning snack had been delivered to her. The staff could be heard indicating a sandwich had been prepared for another resident but not Resident F. The staff could be heard indicating they would prepare and deliver a sandwich, and make sure Resident F was on the list for snacks. During interview on 8/15/11 at 1:20 p.m., Resident F indicated she had received no snack on Saturday or Sunday evenings (8/13 and 8/14/11) . She indicated the dietary department had not delivered snacks either evening. She indicated she had a headache on account of not having her snack. She indicated on Sunday evening, the nurse had bread and cheese to offer her, but she preferred a lunch meat sandwich for a snack, but the nurse told her the kitchen was closed. During interview on 8/15/11 at 1:25 p.m., the Dietary Manager indicated the evening snacks are delivered to the nursing units at 7:00 p.m. as the last task before dietary staff leaves for the evening. The Dietary Manager indicated she could "pull on the Care Tracker system" the percentage of			

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	snacks consumed by the resident. On 8/15/11 at 1:50 p.m., the Dietary Manager provided copies of the Snack List and Care Tracker record for the week of 8/8 through 8/15/11. Care Tracker indicated the resident ate an average of 100% of evening snacks and no percentage of morning snacks. Documentation did not indicate a day by day snack consumption. The Snack List indicated Resident F was to receive peanut butter or cheese crackers and a meat sandwich as a morning snack and a meat sandwich as an evening snack. A notation on the list indicated, "Make sure all meat sand [sandwiches] have 3 sl [slices] meat 1 sl cheese unless stated." During interview at the Exit Conference on 8/15/11 at 3:00 p.m., the DON indicated on Friday (8/12/11) Resident F received a multi-pack of cheese crackers to have for snacks. The DON indicated Resident F ate all the crackers at one time on Friday. This federal tag is related to Complaint IN00094580. 3.1-35(g)(2)			

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure care was provided as ordered by the physician and assessment and care planning related the resident's rectal pain were completed for 1 of 1 resident reviewed related to rectal pain in a sample of 5. (Resident C) Findings include: The clinical record for Resident C was reviewed on 8/13/11 at 12:25 p.m. A Progress Note, dated 7/26/11 and signed by the nurse practitioner, indicated, "Subjective: ...Pt [patient] also C/O [complains of] rectal pain." "Objective" data indicated no examination related to the resident's rectum. "Assessment" indicated, "...Hemorrhoids." A physician's order, dated 7/26/11, indicated, "Annusol cream to rectum qd [every day] & prn hemorrhoid or rectal pain." The Medication Administration Record (MAR) for the entry for Annusol indicated a nurse's initials with a circle around on	F0309	F 309 Resident C no longer resides at the facility. An audit was conducted to identify residents that have a diagnosis of hemorrhoids. Identified residents were assessed and bowel care plans and pain care plans were updated as needed. Staff were re-educated on performing assessments and updating bowel and pain care plans/assessments. New physician orders will be reviewed by the Interdisciplinary Team to ensure pain assessments and care plans are completed and updated. An audit will be completed by the ADON/Designee 5 x weekly for 6 months to ensure compliance. DON/designee will review audits 5 X weekly for 6 months. Identified non compliance of assessments and care plans will result in 1:1 re-education with progressive discipline up to and including termination. Results of the audits are reviewed by the QA committee for recommendations. Systemic changes will be completed by 9-12-11	09/12/2011

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	7/27 and 7/28/11. Documentation failed to indicate the meaning of the circles. The MAR indicated no nurse's initials to indicate the medication was administered on 7/30/11. The medication was administered on 7/31 and 8/1 through 8/5/11, when the resident was discharged to another facility. The Care Plan section of the record dated 8/1/11 failed to indicate a care plan was developed or care was planned related to the resident's rectal pain and hemorrhoids. During interview on 8/15/11 at 11:40 a.m. related to an assessment of the resident's rectal pain and hemorrhoids, the DON indicated unless the resident was a Medicare resident or something was out of line, the nurse would not document about it. When interviewed as to whether the resident's hemorrhoids were internal or external or bleeding, or if the pain was relieved by the treatment, the DON indicated she would need to ask the nurse, since an assessment was not documented and the problem had not been added to the care plan. During the interview, the DON indicated the circled initials on the MAR meant the medication was not administered and the MAR should include an indication of why the medication was not administered.			

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F0328 SS=G	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on record review and interview, the facility failed to ensure a resident reported by family to have a cough was assessed, that the physician was contacted timely, and that care was planned and implemented for management of the respiratory care. The deficient practice resulted in delay in medical evaluation. Evaluation resulted in treatment for pneumonia. The deficient practice affected 1 of 3 residents reviewed related to respiratory care in a sample of 5. (Resident C) Findings include: The clinical record for Resident C was reviewed on 8/13/11 at 12:25 p.m.	F0328	F 328 Resident C no longer resides at the facility. Audit was completed to identify current residents with physicians orders for nebulizer treatments. Identified residents were reassessed and physicians were notified of residents current condition to clarify and update current physician orders as prescribed. Staff re-educated regarding respiratory flow sheets, proper notification of physician and when notification will be indicated per physician orders. Respiratory flow sheets will be reviewed 5 x weekly for 6 months to ensure proper documentation is completed and physician is	09/12/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Physician's orders, dated 6/2/11, indicated the resident was prescribed Levaquin (antibiotic) 500 milligrams twice daily for pneumonia. Nursing Progress Notes, dated 6/29/11 at 12 noon indicated, "[Name], FNP [Family Nurse Practitioner] seen [sic] pt [patient] today d/t [due to] family states she is congested and cough worried that she may have pneumonia again. Cough @ night. [Symbol for no] new orders @ this time." A Progress Note, signed by the nurse practitioner and dated 6/29/11, indicated and "Acute" visit with "Subjective: Pt. [patient] very drowsy. Family reports cough at night. Nurses have not heard cough. Pt. states she would 'sleep even more if they would let me.'" Objective data indicated, "...Recent vital signs: afebrile...Lungs: Within normal limits/clear...Sinuses non-tender. Slight amount of drainage down throat....Assessment: Cough not significant. Lethargy...Plan: Recheck: As necessary....Drowsiness continues [symbol for with] behaviors stay stable may consider [arrow pointing down] Xanax. For now will observe." An Accident/Incident Report, dated		notified per orders and facility policy. DON/Designee will review audits 5 x weekly for 6 months. Identified non compliance of POC will result in 1:1 re-education with progressive discipline up to and including termination. Results of the audits are reviewed by the QA committee for recommendations Systemic changes will be completed by 9-12-11	

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	155328	A. BUILDING 00 B. WING	08/15/2011

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	6/14/11, and Nursing Progress Notes, dated 6/14/11 at 9:00 a.m. and 10:00 p.m. indicated the resident's most recent vital signs were measured on that date. Nursing Progress Notes for 7/4/11 at 1:20 p.m. indicated, "Call placed to triage D/T family (daughter) states mother has congestion & cough wants atb [antibiotic] & neb [nebulizer] tx [treatment]. Reported seen by [name of attending physician] on 6/23/11 and [name of nurse practitioner] on 6/29/11 [symbol for with] [symbol for no] new orders. Will send info to [name of attending physician] in am [morning]. Resident LOA [leave of absence] [symbol for with] family." Nursing Progress Notes for 7/4/11 at 1:30 p.m. indicated, "Daughter notified that triage will notify [name of attending physician] in a.m. verbalize understanding." Nursing Progress Notes for 7/4/11 at 1:45 p.m. indicated, "Triage returned call. States [name of attending physician] called in new orders received. Daughter notified." Physician's orders, dated 7/4/11, indicated, "Robitussin [cough medication] 2 tsp [teaspoons] q [every] 4 [symbol for hours] prn [as needed] cough" and "Albuterol			

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	U/D [unit dose] q 4 [symbol for hours] prn cough." Nursing Progress Notes for 7/4/11 failed to indicate when the resident returned from leave of absence with family on that date. The Medication Administration Record (MAR) for 7/4/11 indicated the resident received medications at the facility on 7/4/11 at 8:00 p.m. Documentation in Nursing Progress Notes failed to indicate an assessment of the resident's vital signs and respiratory system, including cough, breath sounds, and oxygen saturation from 6/15 through 7/8/11. No Progress Notes were recorded from 7/4/11 until 7/8/11. Documentation on the MAR and Respiratory Treatment Record indicated no doses of the nebulizer treatment were administered from 7/4/11 until 7/8/11 at 8:00 p.m. During interview on 8/13/11 at 12:15 p.m. in regard to location in the clinical record for vital signs and respiratory assessments, the Director of Nursing (DON) indicated vital signs and respiratory assessments would be in Nursing Progress Notes. Nursing Progress Notes for 7/8/11 at 2:30			

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	p.m. indicated, "Chest X-ray today d/t congestion. Family request tx to be routine. Triage will return call [symbol for with] orders regarding breathing tx." Nursing Progress Notes for 7/8/11 at 2:40 p.m., indicated, "X-ray notified of order." Nursing Progress Notes for 7/8/11 at 6:00 p.m., indicated, "N/O [new order] per triage. Albuterol Neb tx BID et [and] q 4 [symbol for hours] prn. Pharmacy notified. Left message for family." Report of a chest x-ray, dated 7/8/11, indicated the document was faxed from radiology on 7/8/11 at 8:56 p.m. The report indicated, "Impression: Chest: Mild pulmonary vascular congestion in both lower lung fields. Comment: ...Clinical correlation is requested...." A stamped "Faxed" on the report indicated, "7/9/11." During interview on 8/15/11 at 11:30 a.m., in regard to when the physician was notified of the results of the chest x-ray for 7/8/11, the DON indicated the physician would have received the report before the facility so would have been aware of the report when orders were received for nebulizer treatments twice daily on 7/8/11 at 6:00 p.m. Documentation failed to indicate the			

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	physician was made aware of the results of the chest x-ray and need for clinical correlation. Documentation in Nursing Progress Notes for 7/8/11 until 7/13/11 failed to indicate vital signs and respiratory assessment. No Nursing Progress Notes were recorded from 7/8/11 until 7/13/11. The Respiratory Treatment Record for July 2011 for "Albuterol U/D q 4 [symbol for hours] prn cough" indicated the nebulizer treatment was administered 7/9/11 at 8:00 a.m. and included pulse and respiratory rates and breath sounds of wheezes and diminished before and after the treatment. Documentation failed to indicate the physician was notified of the breath sounds. Other doses were administered one to two times daily through 7/16/11, with indication of pulse and respiratory rates and breath sounds of clear/diminished or diminished before treatments and clear/diminished or clear after treatments. Documentation failed to indicate the physician was notified of the diminished breath sounds. Documentation failed to indicate an assessment related to the need for the prn doses of the nebulizer treatment. The MAR indicated routine doses of the Albuterol nebulizer treatment were			

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	administered at 8:00 a.m. and 8:00 p.m. from 7/8/11 at 8:00 p.m. through 7/16/11 at 8:00 a.m. Documentation failed to indicate assessments related to the routine treatments Nursing Progress Notes for 7/13/11 at 8:30 a.m., indicated, "Returning from rehab dining. Color pale. Unable to walk. Placed in W/C [wheel chair] returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective: ...Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distress...pale, warm, ashy around lips, does have occasional cough, Lungs: within normal			

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	limits/clear; rales [sic]...lack of muscular coordination. When re [checkmark] about an hour later, pt alert, color good, talking & visiting [symbol for with] family. O2 still variable, but breathing reg [regular] & even, non-labored....Plan: Recheck as necessary...." Physician's orders, dated 7/13/11, indicated, "O2 at 2-4 L/PNC. Keep sats greater than 90%, IV D5NS @ 60/hr [sic]. Stat [immediate] chest x-ray, CBC [complete blood count], BMP [basic metabolic profile], UA & C&S [urinalysis with culture and sensitivity." A report of the chest x-ray, dated 7/13/11, indicated, "Impression: Chest: ...infiltrate in the right lower lung field....Comment: ...infiltrate in the right lower lung field. The lung fields are otherwise essentially clear." Physician's orders, dated 7/13/11 at 1:00 p.m., indicated, "Levaquin 500 mg po [by mouth] dly [daily] X [for] 10 d [days] pneumonia...." This federal tag is related to Complaint IN00094580. 3.1-47(a)(6)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure the use of an	F0329	F 329 Resident C no longer resides at the facility. An audit was conducted by the	09/12/2011

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	antipsychotic medication was indicated, and failed to ensure an attempt at gradual dose reduction for 1 of 3 residents reviewed related to antipsychotic medications in a sample of 5. (Resident C) Findings include: The clinical record for Resident C was reviewed on 8/13/11 at 12:25 p.m. The record indicated the resident was admitted to the facility on 11/23/10 following a stay at a behavior unit upon referral from a local hospital emergency room where she had been taken by family no longer able to manage her care at home. The list of the resident's home medications on the Psychiatric Consultation, dated 11/13/10, did not include the antipsychotic medication, Zyprexa. Physician orders upon admission indicated a prescription for one oral Zyprexa 7.5 tablet daily. The Mood and Behavior Symptom Assessment/Plan of Care, originally dated 11/24/11, and most recently updated 8/1/11 indicated the resident received Zyprexa related to the diagnoses of Alzheimer's dementia with behaviors and		Interdisciplinary Team to identify current residents on psychotropic medications to ensure gradual dose reductions (GDR) are being preformed per State and Federal regulations. Facility staff were re-educated on documentation of resident behaviors and gradual dose reductions. Interdisciplinary Team will review the monthly psychopharmacological resident utilization summary report that is provided by the pharmacy to ensure a GDR is attempted unless contraindicated for current psychotropic medication residents are prescribed to ensure State and Federal regulations are being followed. DON/designee will audit the Interdisciplinary Teams findings monthly for 6 months to ensure GDRs are being attempted unless contraindicated. Results of the audits are reviewed by the QA committee for recommendations. Systemic changes will be completed by 9-12-11	

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	psychosis. The resident's "Compressed Mood and Behavior Report" (a computer print out summarizing behavior monitoring) for 11/23/10 through 8/5/11, when the resident was discharged to another facility, indicated the resident had no behaviors. A Consultation Report, dated 5/10/11 through 5/11/11, from the facility's Consultant Pharmacist, indicated, "Comment: [Name of Resident C] has taken Zyprexa 7.5 mg QHS [every bedtime] for dementia w/ [with] psychosis and Trazodone 100 mg QHS for depression. Federal guidelines require evaluation for possible reduction at least twice in the first year of therapy/admission. No behaviors noted on the chart. Recommendation: Please consider a gradual dose reduction, perhaps decreasing to Zyprexa 5 mg QHS (continue Trazadone as currently ordered) while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated. Rationale for Recommendation - The manufacturer's prescribing information includes a BOXED warning which identifies a			

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	potential increased risk of mortality in elderly individuals taking antipsychotic medications of dementia-related behavioral disorders. Federal nursing facility regulations require that antipsychotics being used to manage behavior or stabilize mood undergo gradual dose reduction (GDR) attempts in two separate quarters within the first year in which a resident is admitted on one of these medications or after the facility had initiated the medication, then annually thereafter UNLESS CLINICALLY CONTRAINDICATED." A notation after this information indicated a check mark next to "I decline the recommendation(s) above because GDR is CLINICALLY CONTRAINDICATED for this individual. The resident's target symptoms returned or worsened after the most recent GDR attempt within the facility and a GDR attempt at this time is likely to impair this individual's function or increase distressed behavior as DOCUMENTED BELOW. Please provide CMS [Center for Medicare and Medicaid Services] REQUIRED patient-specific rationale describing why a GDR attempt is likely to impair function or increase behavior in this individual:" Handwritten was, "Still has behaviors at time. [sic] Long term depression." The documentation was signed and dated by the attending physician on 5/24/11.			

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	During interview on 8/15/11 at 1:00 p.m., the Social Services Director and Activities Director indicated Resident C had no behaviors since she lived at the facility. Both indicated the resident was easily redirected and very sweet. During interview on 8/15/11 at 1:30 p.m. in regard to follow-up with the physician related to the absence of behaviors and possible gradual dose reduction for Resident C, the Director of Nursing indicated the physician thought she had been "on the medication so long he just didn't want to take her off - he thought it was just part of her routine." This federal tag is related to Complaint IN00094580. 3.1-48(a)(4) 3.1-48(b)(2)			